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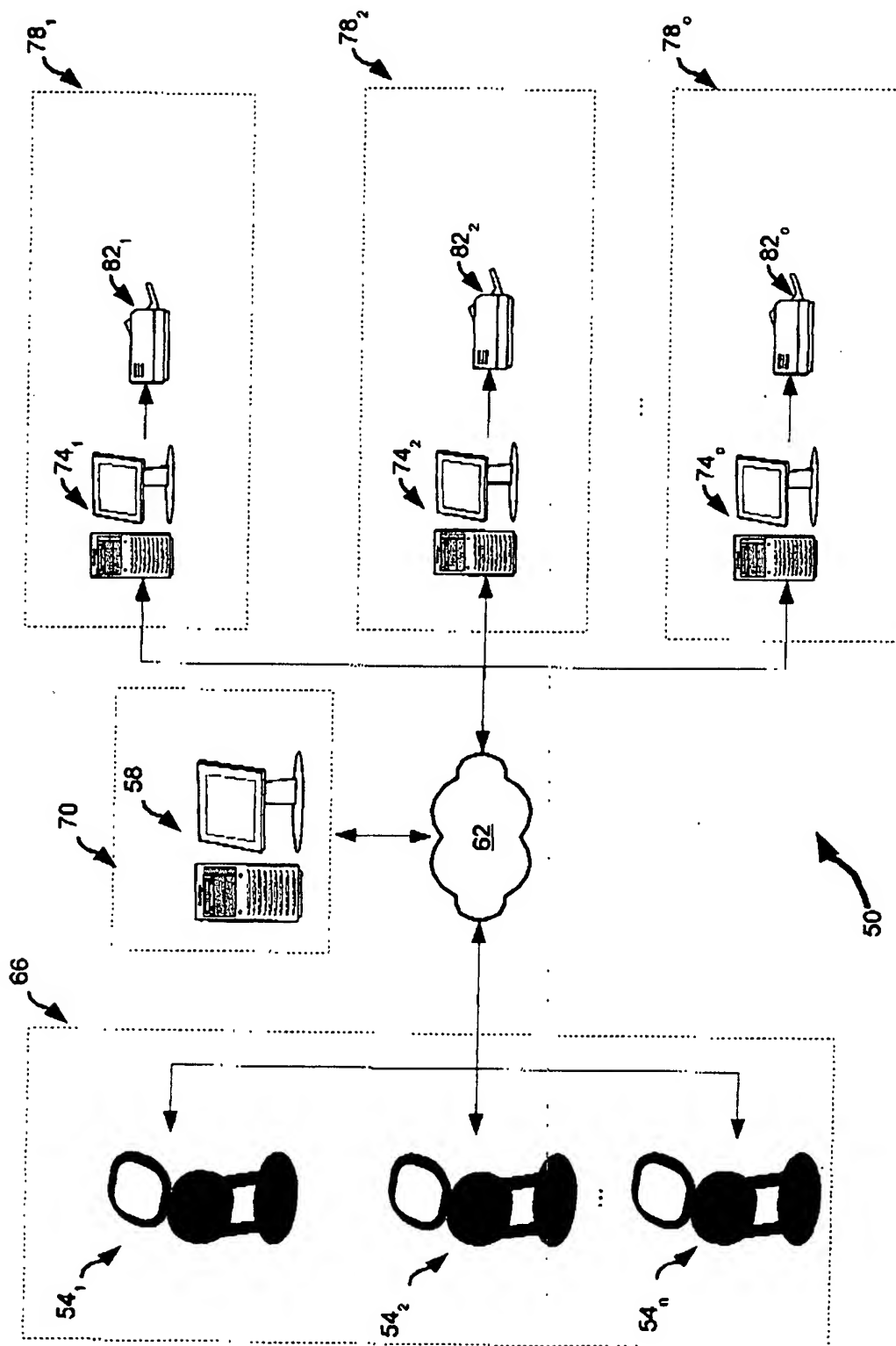
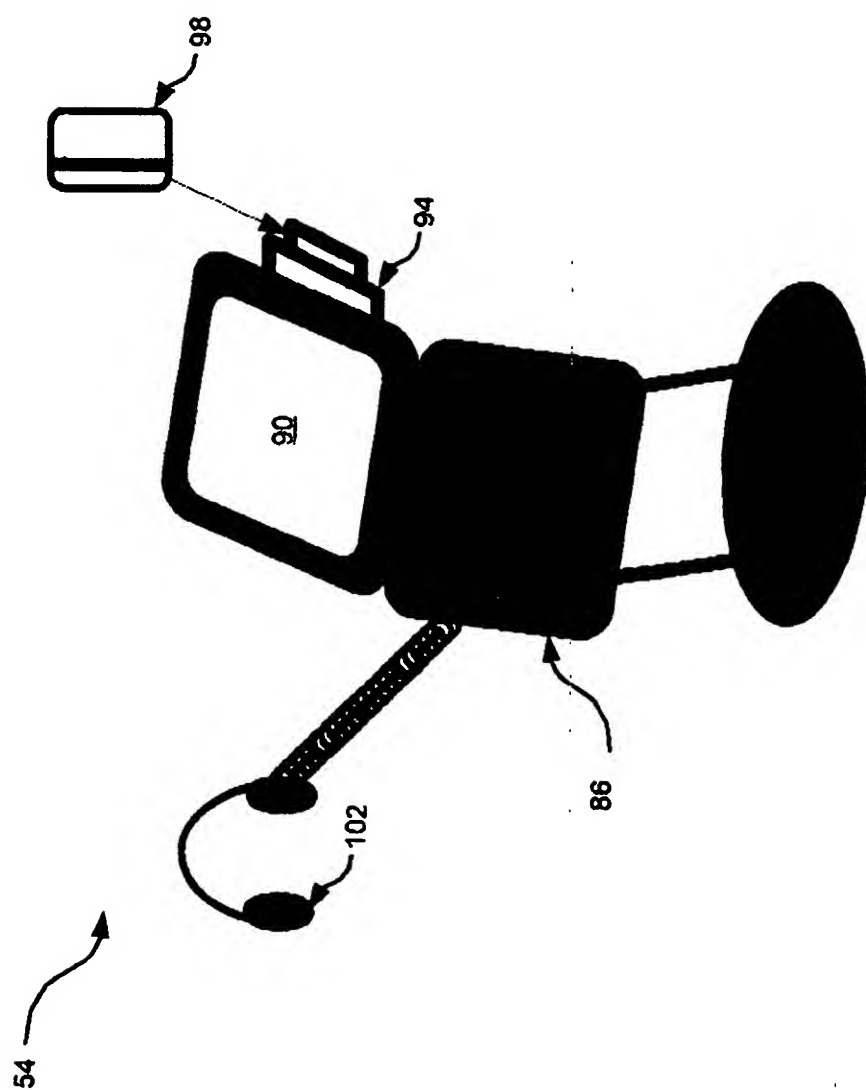


Fig. 1

Fig. 2



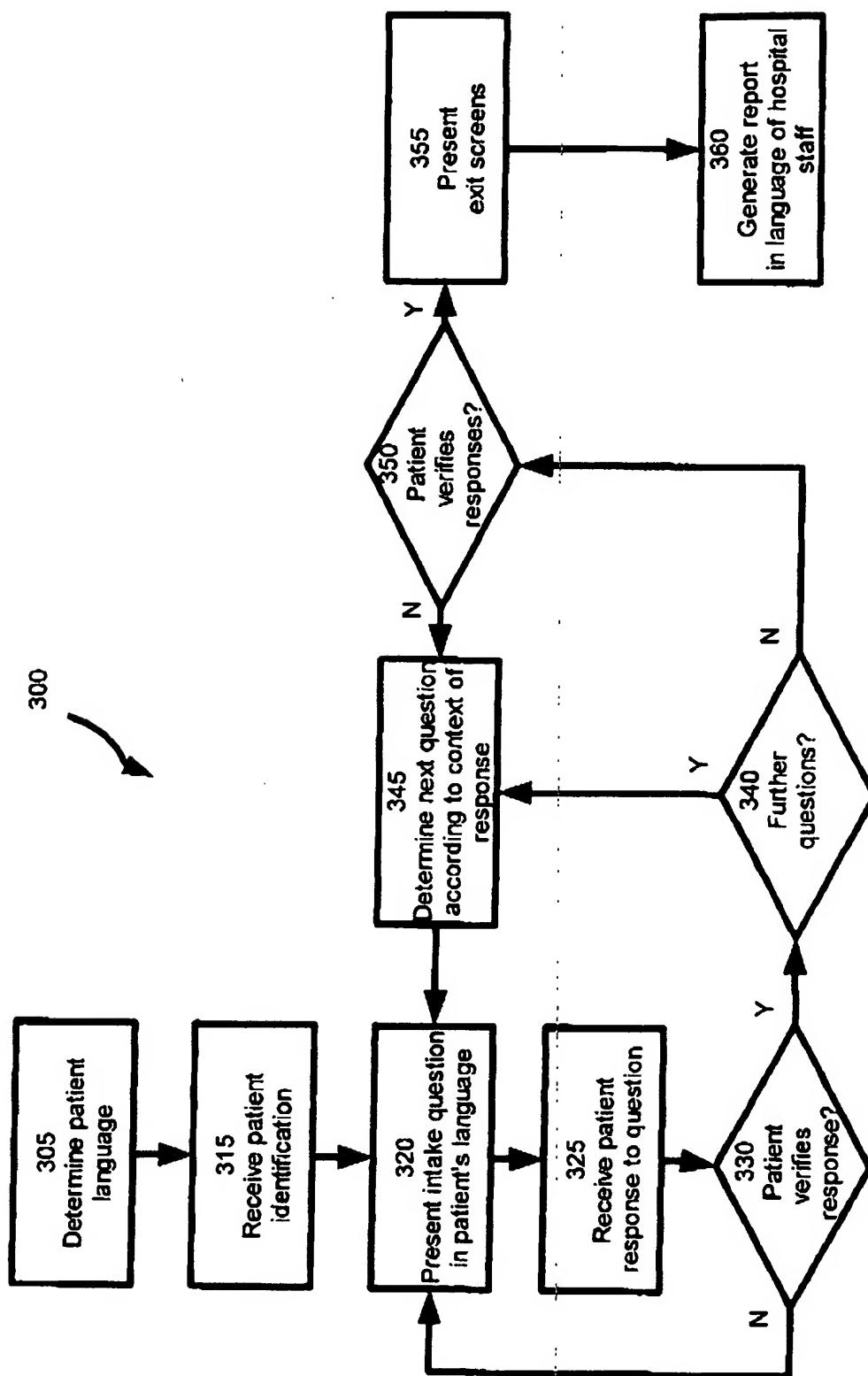
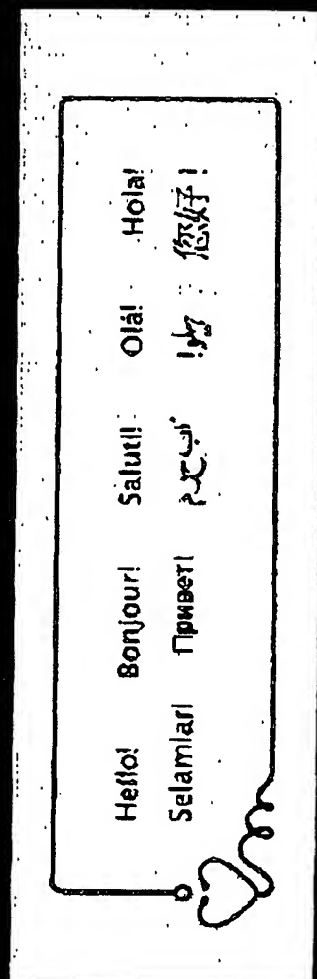
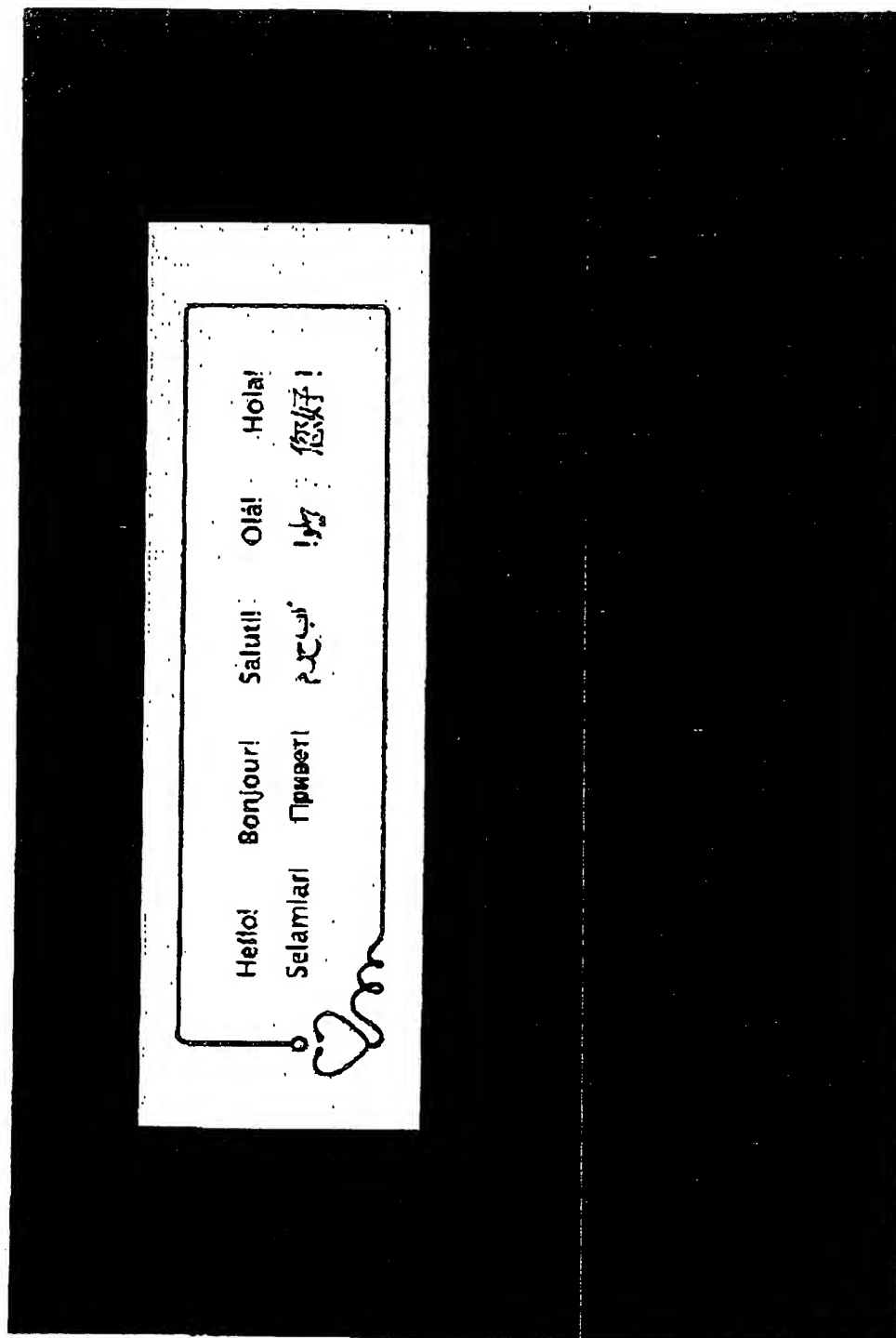


Fig. 3

Fig. 4



Please type your first name and last name.

LINDA OWENS

1	2	3	4	5	6	7	8	9	0
Q	W	E	R	T	Y	U	I	O	P
A	S	D	F	G	H	J	K	L	
Z	X	C	V	B	N	M			
Space					Backspace				

<GO BACK

LISTEN AGAIN

NEXT>

Fig. 5

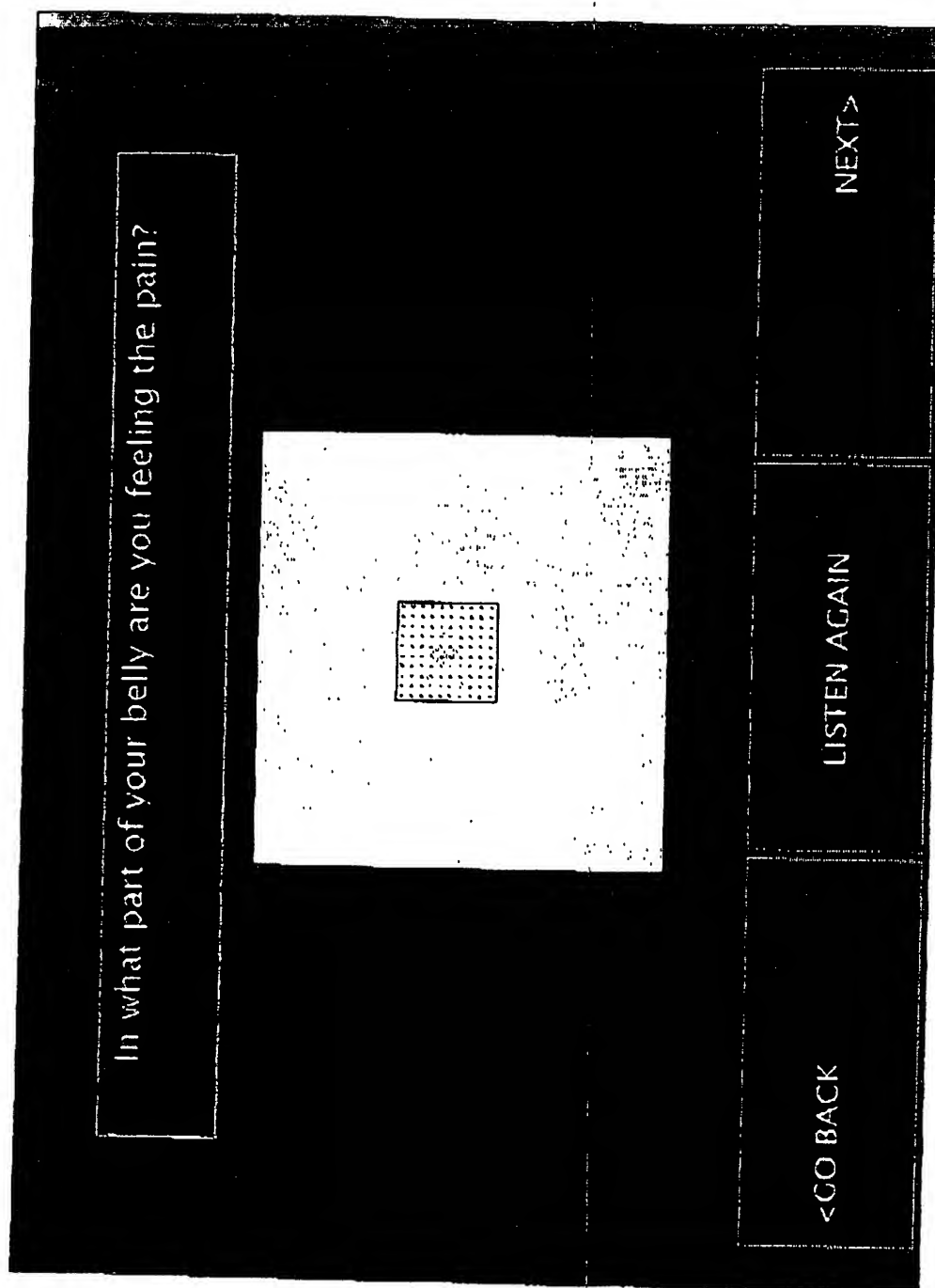


Fig. 8

Fig. 7

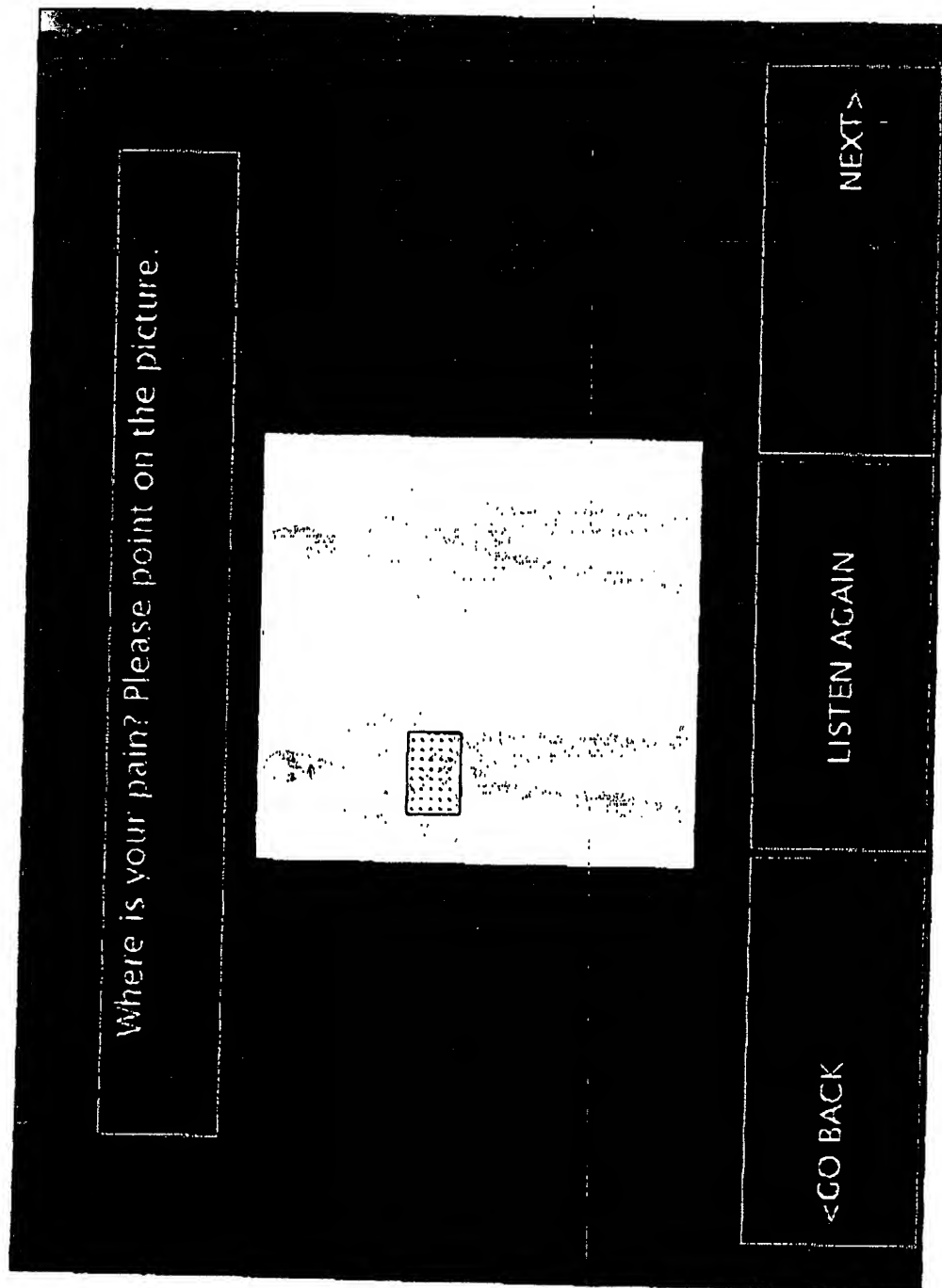


Fig. 9

Thank you, you have completed the automated part of your interview. This is the last question screen. If you wish to go back to earlier questions and change your answers please do it now by pressing the GO BACK button. We need 30 seconds to complete processing your file and create a printed report for your physician at the administrator's desk. Would you like to finish now?

Yes No

<GO BACK LISTEN AGAIN NEXT

This automated part of your interview allows you and your physician to have a head start for your real live interview. Please note that you still have to talk to your physician more about all your complaints. We wish you a speedy recovery. Thank you very much for your time and cooperation. Would you like to save this information so it could be available for your future visit?

YES NO LISTEN AGAIN

Fig. 10

Fig. 11

Hospital Intake Report

INTRODUCTION Name <u>JUNDA OWENS</u> Age: <u>33</u> Gender Female Pregnant? NO LMP < 4 wks ago <input checked="" type="checkbox"/> First visit Reporting: New problem Reason for visit Pain <input checked="" type="checkbox"/> Interview completed		PAST MEDICAL HISTORY 1 PMH: Stomach, esophagus, bowel dis Has <u>HEART BURN</u> <input checked="" type="checkbox"/> Medical tests Name <u>BLOOD TEST</u>
PAIN Pain in: Abd Abd pain in: Periumbilical <input type="checkbox"/> Radiation <input checked="" type="checkbox"/> First time <input checked="" type="checkbox"/> Suddenly Started: in 4-24h Intensity: >5 <input checked="" type="checkbox"/> Increasing Rhythm: constant Quality: dull <input type="checkbox"/> Pain trigger event Comes during: rest <input type="checkbox"/> Eating triggers <input type="checkbox"/> Back pain		PAST MEDICAL HISTORY 2 <input type="checkbox"/> Hypertension <input type="checkbox"/> CIS ulcer <input type="checkbox"/> Liver dis <input checked="" type="checkbox"/> Abd surgery Abd surg > 1 mo ago <input type="checkbox"/> DM <input type="checkbox"/> Migraine <input type="checkbox"/> Head trauma
CVS AND RESPIRATORY SIGNS AND SYMPTOMS <input type="checkbox"/> Cough <input type="checkbox"/> Sore throat <input type="checkbox"/> Leg claudication <input type="checkbox"/> Pedal edema		ASSOCIATING SYMPTOMS <input checked="" type="checkbox"/> Nausea <input checked="" type="checkbox"/> Vomit <input type="checkbox"/> Blood like vomit Vomited: < a glass Vomiting: in last 4h <input checked="" type="checkbox"/> Weight loss Lost: < 10 lb <input type="checkbox"/> Sweating <input type="checkbox"/> Fever Appetite: DECREASED
PERSONAL HISTORY <input checked="" type="checkbox"/> Alcohol Alcohol/wk < 3 times Smoking YES Smoked >10 yrs Daily smoking <10 <input type="checkbox"/> Social support Work: Office work <input checked="" type="checkbox"/> Travel		MEDICATIONS AND ALLERGIES <input checked="" type="checkbox"/> OCD medication Using <u>ASPIRIN</u> <input type="checkbox"/> Prescribed <input checked="" type="checkbox"/> Allergic to <u>PEANUTS</u>
GASTROINTESTINAL SIGNS AND SYMPTOMS <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Dark urine <input type="checkbox"/> Dysphagia <input type="checkbox"/> Abd distension		GENTOURINARY SIGNS AND SYMPTOMS <input type="checkbox"/> Dysuria <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Frequency <input type="checkbox"/> Sexually active
PSYCHIATRIC SIGNS AND SYMPTOMS Mood: SAME Energy: SAME Sleep: SAME Memory: SAME Social life: ACTIVE		MUSCULOSKELETAL SIGNS AND SYMPTOMS <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint effusion
ENDOCRINOLOGIC SIGNS AND SYMPTOMS <input checked="" type="checkbox"/> Polydipsia <input type="checkbox"/> Polyuria <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance <input checked="" type="checkbox"/> Eye problems <input type="checkbox"/> Skin changes <input type="checkbox"/> Hair changes		HEMATOLOGIC SIGNS AND SYMPTOMS <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Easy bruising <input type="checkbox"/> Epistaxis <input checked="" type="checkbox"/> Nodule, mass: Nodule/Mass in: Back
OB/GYN SIGNS AND SYMPTOMS <input type="checkbox"/> Hormone therapy <input type="checkbox"/> Perty <input type="checkbox"/> Miscarriage <input checked="" type="checkbox"/> Gyno procedure Had <u>CAPAROSCOPY</u>		NEUROLOGIC SIGNS AND SYMPTOMS <input checked="" type="checkbox"/> Headache <input type="checkbox"/> Convulsion or syncope <input type="checkbox"/> Numbness <input type="checkbox"/> Up ext weak <input type="checkbox"/> Low ext weak <input type="checkbox"/> Tremors <input checked="" type="checkbox"/> Urinary incontinence <input type="checkbox"/> Fecal incontinence

What brings you here today?

Pain		
Bleeding		
Injury		
Worsening of existing condition		
Shortness of breath		
Other		

<GO BACK

LISTEN AGAIN

NEXT >

Fig. 6